KMA Testimony to the Kentucky E-Health Board
March 5, 2008

Good afternoon, I am Patrick Padgett, Executive Vice President of the Kentucky Medical Association. I appreciate the opportunity to share some of our views on e-health with you today. The centerpiece of our legislative program this year is an effort to address the physician workforce shortage in Kentucky, which was highlighted in a recent study conducted by the Kentucky Institute of Medicine. Part of our workforce plan is to support e-health because we believe that e-health has the potential to save money and improve quality of care. But we also believe that the adoption of e-health will streamline the current morass of administrative work that unfortunately dominates our health care system today.

The KMA has been active on this issue for several years and in several different ways. We have an internal committee looking at issues associated with e-health. We have conducted three surveys of our membership regarding their use of e-health systems. And our annual convention was dedicated to the issue a few years ago, which was highly popular with our members.

The KMA was also an early proponent of Senate Bill 2 that created the E-health Board and we have participated on workgroups and committees tasked by this Board to address various facets of e-health. Much has been accomplished. And we are most appreciative of the bi-partisan nature of the Board and its ability to hear every side of an issue before acting. On numerous occasions, we have been asked to provide our thoughts and opinions on issues and projects, and we appreciate those opportunities. Perhaps most importantly, we have representation on the E-health Board through Doctor Bensema and Doctor Williams, both of whom provide a physician's perspective on this issue. We are grateful to have such quality representation on the Board.

Today, I would like to highlight five areas of e-health that concern our members. The Board has touched on all of these issues, but we hope to have additional dialogue on them in the future. First is patient privacy. The Board's workgroup on privacy did an excellent job drafting an outline of issues and we are glad that the RHIO's in the state have included consumers in their work. We believe the public should continue to be informed of efforts to make their information more readily accessible. While it is certainly beneficial for those in the medical community to exchange information quickly and easily, patients may not be as eager to have

their information so accessible. If they are not informed on these issues, it is the practicing physicians and other medical providers who must deal with the backlash of patients wondering how their information was accessed so easily.

The second issue that concerns us is the priorities within what everyone refers to as "e-health." Most of the discussion both at the local and national levels deals with the electronic exchange or storage of patient health information. We believe, however, that the administrative side of e-health should not be overlooked. For instance, the quick, efficient submission of claims is important to physicians, providers and third party payers, as well as the timely payment for those claims. So is the ability to efficiently credential physicians with minimum administrative time and delay. As we look at simplifying the exchange of patient information, we must also look at simplifying the administrative side of practicing medicine. The benefits of greater administrative efficiencies will, we believe, lead to greater adoption of e-health generally by physicians.

Our next concern centers around the barriers to e-health adoption. Cost, of course, is a significant factor. According to a membership survey we conducted two years ago, cost is the principal barrier to

adopting an electronic health record system. We will continue to explore incentives – financial and otherwise – to assist in the implementation of e-health.

But there are other barriers to electronic health record adoption besides cost. Fear of something new, significant disruption in a practice, and even the inability to type stand as significant barriers to e-health adoption. In many areas, the fear of a system shutdown is very real since there are no local resources to fix the most minor system flaw. While most, if not all of the areas around the state have high speed internet connections, there are many physician practices that are either unaware of this or unaware of how the internet might assist in their practices. These are very real issues for practicing physicians, and beyond financial assistance, they need help in educating themselves and their office staffs on the use of technology.

The e-health network action plan for Kentucky adopted by this board recommends that the state form an "e-health center of excellence" that would provide information, education and assistance to practices interested in adopting e-health, whether in the form of electronic medical records, access to high speed internet,

or administrative systems. Health Care Excel's DOC-IT program used grant money to provide free consulting services to primary care physicians across the state regarding e-health adoption. I believe this program was very successful in educating the physician community and I think the state could easily provide similar services at minimal cost or no cost if grant money could be obtained.

Our fourth issue centers around the inability of systems to transfer data from one system to another. In a city such as Louisville or Lexington, at the present time, physicians cannot simply store patient information in an electronic system and transfer that information to any hospital, nursing home or pharmacy in town. That appears to be the promise around e-health adoption, but as more facilities and practices adopt electronic health records, that promise appears no closer to fruition that it was five years ago. I have heard on countless occasions physicians lament the fact that they have spent thousands of dollars on a system, but cannot transfer the data electronically because their system is not compatible with the local hospital or other physician practices. As more physicians, especially in small practices, hear about this problem, they ask themselves, "Why should I do it?"

Finally, the KMA continues to work to overcome some of these barriers and assist in the adoption of e-health and formation of e-health networks throughout the state. We will also, however, oppose any attempts to mandate the implementation of costly systems or impose costs on physicians for using or accessing such systems. Such expenses only hinder the adoption of e-health and simply add costs with no tangible benefits for the physician or the patient.

I would like to thank you for the invitation to speak today and look forward to continuing KMA's association with the E-health Board, the administration and the entire medical community so we can improve the quality of care in this state, improve administrative efficiency, and create systems that entice more physicians to practice in our state.